

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

07447

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Parsonsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
at home - Parsonsburg  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Parsonsburg  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. R.D.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Rider Edwin Adkins

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Alberta M. Adkins  
 7. Birth date of deceased (mo., day, yr.) August 30 - 1905 6.(c) If alive, give age 40 years  
 8. AGE: Years 41 Months 11 Days 20 If less than one day  
 hrs. min.

9. Birthplace Pittsville Maryland  
 (Town, county, and state)

10. Usual occupation Farmer

## 11. Industry or business

12. Name Ernest Adkins  
 13. Birthplace Pittsville Maryland  
 14. Maiden name Esabelle Freeman  
 15. Birthplace Wango Maryland

16. Informant Mrs. Alberta M. Adkins  
 Address R.D. Parsonsburg Maryland

17. Buried Date hereof August 22, 1947  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Parsonsburg Church Cem.  
Parsonsburg Maryland  
 Location Holloway Co. Route 11, N. Hill

18. Funeral director Salisbury Maryland  
 Address Salisbury Maryland

19. 8/22/47 19 47  
 (Date recd by registrar) Registrar Robert R. Starn

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 20, 1947 at 7:55 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from did not attend  
 and that I last saw him alive on 19 19

Immediate cause of death Coronary Artery  
Occlusion DURATION 12 hrs

Due to.....  
 Due to.....

Other conditions.....  
 (Include pregnancy within 3 months of death)

Major findings of operations.....  
 Date of op.....

Autopsy results.....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)  
 Injured at work?

23. SIGNATURE Robert R. Starn  
Robert R. Starn M. D. or other

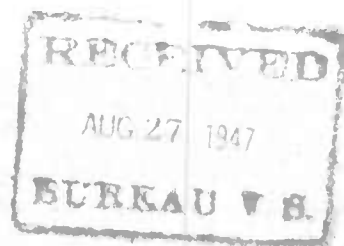
Address Salisbury, Md. Date signed 8-20-47

MARGIN RESERVED FOR BINDING

VS A15

9-45

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Use correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07448

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

## MEDICAL CERTIFICATION

Female

White

Widow

20. DATE OF DEATH

Aug. 8th

1947 525p

6. (b) Name of husband or wife

Langston Sanford Bell

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

7. Birth date of

deceased (mo., day, yr.)

Feb. 11-1881

6. (c) If alive, give age... years

and that I last saw h... alive on

19...

8. AGE:

Years

Months

Days

If less than one day

66

5

27

hrs.

min.

9. Birthplace

Oddville Maryland

(Town, county, and state)

10. Usual occupation

Home life

11. Industry or business

at home

FATHER

12. Name

Larnet Meredith

MOTHER

13. Birthplace

Oddville Md.

14. Maiden name

Hester Cannon

15. Birthplace

Oddville Md.

16. Informant

Miss Cecil Bell

Address

401. Baker St. Salisbury Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematorium

Salisbury Md. Park

Location

Salisbury Md.

18. Funeral director

Hillman, G. Walter R. Hillman

Address

Salisbury Md.

19. Date rec'd by registrar

8/11/47

19

H. Y. Barriett

Johnston

23. SIGNATURE

L. R. Gramp M.D.

M. D. or other

Address

Salisbury Md.

Date signed

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

I

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 18 1947  
BUREAU V B

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 yrs.

Hospital, institution, or street address where death occurred:

510 Camden Ave. Salisbury

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md County WicomicoCity or town Salisbury  
(If outside city or town limits write RURAL and give nearest town)Street No. 510 Camden Ave  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Celeste B. Breivington

## 3. (b) Social Security Number

4. Sex

7

5. Color or race

Col.

6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife Clarence Breivington

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 30, 1861

8. AGE: Years Months Days If less than one day

86 11 15 \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Fruitland, Wicomico, Md.  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Josiah Mc. Grath13. Birthplace Fruitland, Md.14. Maiden name Elnora Robertson Mc. Grath15. Birthplace Fruitland, Md.16. Informant Mrs. Harry BreivingtonAddress 510 Camden Ave. Salisbury17. Burial 8/18/47  
(Burial, cremation, or removal. Which? 8/18/47)Cemetery or crematory SalisburyLocation Salisbury18. Funeral director E. G. M. LewisAddress Bisulve, Md.19. 8/18 19 47 Harriet L. Johnson  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 15 19 47 at 2 P. M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 19 46 to Aug 15 19 47and that I last saw her alive on Aug 12 19 47Immediate cause of death Valvular Heart DiseaseDURATION unknown

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Coronary Vas - neptulesCarcinoma left Breast

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE John R. Mame

M. D. or other \_\_\_\_\_

Address Salisbury Md Date signed 8/15/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 26 1947

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should be carefully supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Department of Commerce  
Bureau of the Census

CERTIFICATE OF DEATH  
COMMONWEALTH OF VIRGINIA No. 176  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL STATISTICS

State File No.

07450

Registered No. 333

## 1. PLACE OF DEATH

(a) County Accomack Registration district No. 1 (For reg. use)  
(b) Magisterial district Salisbury  
(c) City or town Chincoteague  
(d) Name of hospital or institution P. H. Hospital  
(e) Length of stay in hosp. or inst. In this community  
(Specify whether years, months, or days)  
(f) Is place of death within corporate limits? yes

## 2. USUAL RESIDENCE OF DECEASED

(a) State Virginia  
(b) County Accomack  
(c) City or town Chincoteague Street No. 1  
(d) Is place of residence within corporate limits? yes  
(e) Citizen of foreign country? no (Yes or No) ☒  
If Yes, name country \_\_\_\_\_

## 3. (a) FULL NAME

Harney Lee Carpenter

3. (b) If veteran,  
name war \_\_\_\_\_

3. (c) Social security  
number 562-05-1399  
(Answer only if card is available)

4. Sex

male

5. Color or race

white

6. (a) Single, married, widowed, divorced.

Divorced

8. (b) Name of husband  
or wife \_\_\_\_\_

7. Date of birth of deceased

march 7, 1900  
(Month by name) (Day) (Year)

8. Age:

Years

Months

Days

If less than one day

47

5

8

hours min.

9. Birthplace

Chincoteague va  
(City, town, or county) (State or foreign country)

10. Usual occupation

Watersman

11. Industry or business

Father {

12. Name Thomas Carpenter

13. Birthplace Chincoteague va  
(City, town, or county) (State or foreign country)

Mother {

14. Maiden name Lillie Reed

15. Birthplace Chincoteague va  
(City, town or county) (State or foreign country)

16. (a) Informant's own signature

Mrs. Lillie Carpenter

(b) Address

Chincoteague va

17. (a) Burial, cremation, or removal?

Burial

(b) Place

Chincoteague va Date Aug 17 1947  
(Month by name) (Day) (Year)

Signature of

Walter M. Barker

18. (a) funeral director

(b) Address

Chincoteague va

19. (a) Filed

8/18/47  
(Date received by reg.)

(b)

Barriett E. Johnson  
(Local, deputy, or sub-registrar's own signature)

## MEDICAL CERTIFICATION

20. Date of death August 15 19 47 at 8:30 P. M.  
(Month by name) (Day) (Year) (Hour)

21. I hereby certify that I attended the deceased from

to 19 ; that I last saw him alive on 19 ;

and that death occurred on the date and hour stated above.

Immediate cause of death multiple injuries

4 3rd degree Burns  
Due to Boiler explosion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Name of operation

Date of operation

Major findings: (a) of operations

(b) of autopsy

Duration

few  
hours

Physician

Underline  
the primary  
cause to  
which death  
should be  
charged  
statistically.

22. If death was due to external causes fill in the following:

(a) Accident, suicide, or homicide (specify) accident

(b) Date of occurrence Aug 16 1947

(c) Where did injury occur? Chincoteague Accomack va  
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place?

Industrial place While at work? yes  
(Specify type of place)

(e) Means of injury Explosion of boiler

23. Signature

Address

J. L. DeComie  
Accomack va

M. D., Cor.,  
or other

Date signed 8/16/47

RECEIVED

AUG 26 1947

BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07451

## CERTIFICATE OF DEATH

Reg. Dist. No. 353

1. PLACE OF DEATH  
County McComick  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
155. Hoyt  
How long in hospital or institution? 5 day 9 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County McComick  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 229 New York Ave  
(If rural, give LOCATION)  
2(a) If veteran, name war

3. (a) FULL NAME  
Jennie Chandler

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
B. (b) Name of husband or wife Henry B. Chandler  
6. (c) If alive, give age Dead years  
7. Birth date of deceased (mo., day, yr.) Sept. 8-1858

8. AGE: Years 88 Months 11 Days 11 If less than one day  
hrs. min.

9. Birthplace Reading England  
(Town, county, and state)

10. Usual occupation at home

11. Industry or business at home

12. Name Unknown (Pendroy)

13. Birthplace Reading England

14. Maiden name Unknown

15. Birthplace Reading England

16. Informant My. George P. Chandler  
Address Box 104 Hill Ave. & Matilda L. Salisbury MD

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Aug 21-47  
(month) (day) (year)  
Cemetery or crematory Wayome Cemetery

Location Salisbury Maryland  
18. Funeral director William H. Walter R. Holliday  
Address Salisbury Maryland

19. 8/31/47 (Date rec'd by registrar) 19 W. L. Harris & E. Johnson Registrar

MEDICAL CERTIFICATION  
20. DATE OF DEATH Aug. 19th 19 47, at 420 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 19 47, to Aug 19 19 47, and that I last saw her alive on Aug 18 19 47.

Immediate cause of death Chronic myocarditis

Due to Anterior retrovirus

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Means of injury Injured at work?

23. SIGNATURE F. R. Grance M. D. or other

Address Date signed

MARGIN RESERVED FOR BINDING

VS A15 9 45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 26 1947

BUREAU T B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

07452

<b>1. PLACE OF DEATH:</b> County <u>Wicomico</u> City or town <u>Hebron Md.</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>life</u> Hospital, institution, or street address where death occurred: How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Md.</u> County <u>Wicomico</u> City or town <u>Hebron</u> (If outside city or town limits, write RURAL and give nearest town) Street No. (If rural, give LOCATION) 2. (a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>John Henry Cook</u>				<b>3. (b) Social Security Number</b>			
<b>4. Sex</b> <u>M.</u>		<b>5. Color or race</b> <u>Col.</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6. (b) Name of husband or wife</b> <u>Zemer Cook</u>				<b>7. Birth date of deceased (mo., day, yr.)</b> <u>unknown</u>			
<b>8. AGE:</b> Years <u>80</u> Months _____ Days _____ If less than one day _____ hrs. _____ min.				<b>8. (c) If alive, give age</b> _____ years			
<b>9. Birthplace</b> <u>Hebron Wicomico Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Farming</u>			
<b>11. Industry or business</b>				<b>12. Name</b> <u>John Cook</u>			
<b>13. Birthplace</b> <u>Hebron Md.</u>				<b>14. Maiden name</b> <u>Sally Anne ?</u>			
<b>15. Birthplace</b>				<b>16. Informant</b> <u>Ruby Boylston</u> Address <u>Hebron Md.</u>			
<b>17. (Burial, cremation, or removal, which?)</b> <u>Burial</u> Date thereof <u>8/24/47</u> (month) (day) (year) Cemetery or crematory <u>Marble Creek</u> Location <u>Marble Md.</u>				<b>18. Funeral director</b> <u>David E. Mesnick</u> Address <u>Hebron Md.</u>			
<b>19. (Date rec'd by registrar)</b> <u>8/26/47</u>				<b>20. DATE OF DEATH</b> <u>8/24/47</u> 19 <u>47</u> at <u>3 A.</u> M.			
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>August 22</u> 19 <u>47</u> to <u>Aug. 23</u> 19 <u>47</u> <b>and that I last saw him alive on</b> <u>Aug. 23</u> 19 <u>47</u>				<b>Immediate cause of death</b> <u>arterial hemorrhage</u>			
<b>Other conditions</b> <u>arteriosclerosis</u> (Include pregnancy within 3 months of death)				<b>MAJOR FINDINGS OF OPERATIONS</b>			
<b>Autopsy results</b>				<b>PHYSICIAN: Please underline the cause to which death should be charged statistically.</b>			
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide _____ Date of _____ Where did injury occur? _____ (City or town) _____ (County) _____ (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____				<b>23. SIGNATURE</b> <u>William E. Smith</u> M. D. or other _____ Address <u>Hebron Md.</u> Date signed <u>Aug. 25-47</u>			

RECEIVED

SEP 3 1947

BUREAU OF



RECEIVED  
AUG 15 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 939

07454

## 1. PLACE OF DEATH:

County... Wicomico  
 City or town... Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 45 years  
 Hospital, institution, or street address where death occurred:  
414 Records St  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Wicomico  
 City or town... Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 414 Records St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

John W. Duncan

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Mary Virginia Duncan

7. Birth date of deceased (mo., day, yr.) April 24, 1867 6. (c) If alive, give age 76 years

8. AGE: Years 80 Months 3 Days 16 If less than one day  
 hrs. min.

9. Birthplace Quail Somerset Co Maryland  
(Town, county, and state)10. Usual occupation Retired Hunter

11. Industry or business

12. Name Cliffa Duncan13. Birthplace Somerset Co, Maryland14. Maiden name Maude Jane Parks15. Birthplace Somerset Co, Md.16. Informant Everett S. DuncanAddress Salisbury, Maryland17. Burial ✓ Date thereof 8/13/47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Parsons CemeteryLocation Salisbury Maryland18. Funeral director The Hall & Johnson CoAddress Salisbury, Maryland19. 8/10 19 47 Registrar W. H. Harris

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 47 at 11:30 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 19 42 to Aug 10 19 47  
 and that I last saw him alive on Aug 3 19 47

Immediate cause of death

Cardio-vascular renaldisease.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Philip A. LinderAddress Salisbury, Md Date signed 8/13/47

M. D. or other

RECEIVED

AUG 26 1947

BUREAU # 8

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

129

07455

## CERTIFICATE OF DEATH

Reg. Dist. No. 222

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

P. H. Hospital, Salisbury, Md.

How long in hospital or institution?

17 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John William Dunn

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

w

6.(a) Single, married, widowed, or divorced

married

6.(b) Name of husband or wife

Julia A. Dunn

7. Birth date of deceased (mo., day, yr.)

June 1, 1894B.(c) If alive, give age 66 years

8. AGE:

Years 53 Months 2 Days 18 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Buwalve, Wicomico, Md.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Henry Dunn13. Birthplace Buwalve, Md.14. Maiden name Melissa Corbourn15. Birthplace Secretary, Md.16. Informant Esther RobbinsAddress Baltimore, Md.17. Burial Church Date thereof 8/23/47  
(Burial, cremation, or removal, which) (month) (day) (year)Cemetery or crematory Buwalve CemeteryLocation Buwalve, Md.18. Funeral director C. F. MessersickAddress Buwalve, Md.19. 8/21/47 Harriet L. Johnson Registrar  
(Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 1947, at 5:15 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 3 1947 to Aug 20 1947and that I last saw him alive on Aug 20 1947

Immediate cause of death

myocardial infarction

Due to

Portulaca, acute

Due to

Coronary artery disease

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

None

Autopsy results

None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

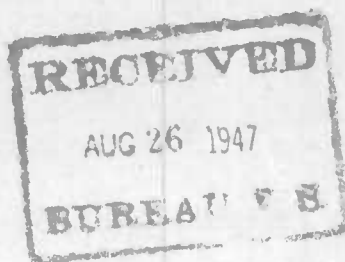
23. SIGNATURE

William B. Long, M.D. M. D. or otherAddress 504 W. DuPont St. Date signed 8/24/47  
Salisbury, Md.

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

518

07456

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Dorchester  
 City or town Upper Fairmount  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Ford, Archie

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Maude B. Ford

## 7. Birth date of deceased (mo., day, yr.)

Oct 3 - 1875

6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

711013

hrs.

min.

## 9. Birthplace

Fairmount, Dorchester, Maryland  
(Town, county, and state)

## 10. Usual occupation

Waterman

## 11. Industry or business

## FATHER

## 12. Name

Thomas E. Ford

## 13. Birthplace

Maryland

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

## 16. Informant

Mr. Carl M. Ford

## Address

Upper Fairmount, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

## Date thereof

Aug. 19, 1947  
(month) (day) (year)

## Cemetery or crematory

M. E. Cemetery

## Location

Fairmount, Md.

## 18. Funeral director

Sherry Station

## Address

Pocomoke, Md.

## 19. Date rec'd by registrar

8/19, 1947H. H. HarrisonRegistrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 16<sup>th</sup> 1947, at 10<sup>25</sup> p.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 9 1947 to Aug. 16 1947and that I last saw him alive on August 16<sup>th</sup> 1947Immediate cause of death Obstruction of ureters DURATION 11 daysMetastatic carcinoma from prostate to retroperitoneal lymph nodes due to carcinoma of prostateOther conditions arteriosclerotic heart disease Unknown

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results See above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE David J. Gilmore M.D.Address 301 N. Division Date signed Aug. 17Salisbury, Md. Date signed 1947

MARGIN RESERVED FOR BINDING

I

9-45-15M

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 47 330

## 1. PLACE OF DEATH:

County Micomico  
 City or town Mardela Springs - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life  
 Hospital, institution, or street address where death occurred:  
San Domingo  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Micomico  
 City or town Mardela Springs - Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. San Domingo  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Royce L. Goslee

## 3. (b) Social Security Number

217-09-2808

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mabel Fooks Goslee  
 6. (c) If alive, give age 28 years  
 7. Birth date of deceased (mo., day, yr.) January 22, 1918  
 8. AGE: Years 29 Months 6 Days 10 If less than one day  
 .....hrs. ....min.

9. Birthplace Micomico County, Maryland  
(Town, county, and state)10. Usual occupation Day Laborer11. Industry or business Farm and Steam Mill12. Name Herman McGlotten13. Birthplace Micomico County, Maryland14. Maiden name Fronia Moore15. Birthplace Micomico County, Maryland16. Informant Mrs. Fronia MooreAddress Mardela Springs, Maryland, R.F.D.17. Burial Date thereof August 15, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory San Domingo CemeteryLocation Near Sharptown, Maryland18. Funeral director J. J. Thompson & SonAddress Federalburg, Maryland19. August 15, 1947 J. J. Thompson  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 12, 1947 at 3:05 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 30, 1947 to Aug. 12, 1947 and that I last saw him alive on Aug. 10, 1947Immediate cause of death 2 tuberculosis Pul  
monia with pleurisy  
associated

Due to

Due to

Other conditions none

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

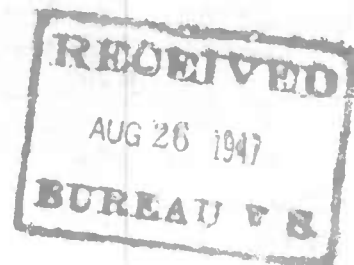
23. SIGNATURE W. J. D. Junior M. D. or otherAddress see above Date signed Aug. 12, 1947

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



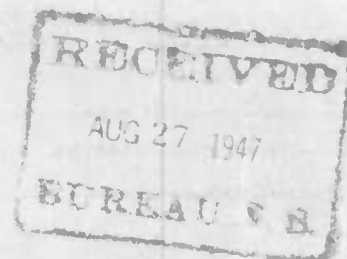
Reg. Dist. No. 333

Address: 12000 1st Ave Date signed 8/21/11

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

170 C

07459

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

### 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Penninsula General Hospital  
How long in hospital or institution? 40 hrs. - 40 min.

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State MD County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.O. #3  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Gully Miss Sarah Ellen

### 3. (b) Social Security Number

4. Sex Female Color or race White  
5. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) July 27 - 1928  
6. (c) If alive, give age 19 years

8. AGE: Years 19 Months 10 Days 4  
If less than one day hrs. min.

9. Birthplace Summit C. Md.  
(City, county, and state)

10. Usual occupation  Clerk

11. Industry or business

12. Name of Father Henry G. Gully  
13. Birthplace Wicomico Miss.

14. Maiden name of Mother May Latta  
15. Birthplace Chincoteague Va.

16. Informant Mr. Henry G. Gully  
Address R.O. #31 Salisbury Md

17. Burial (Burial, cremation, or removal, Which?) Burial  
Date thereof Sept 3-27  
(month) (day) (year)

Cemetery or place of interment McComie Mem. Park

Location Salisbury Maryland

18. Funeral Director William J. K. White R. Hollen  
Address Salisbury Maryland

19. (Date rec'd by registrar) 9/6/47 Registrar H. T. Johnson

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 31 19 47 at 11:20 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to 19  
and that I last saw him alive on 19

Immediate cause of death Fractured skull

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy required

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident Accident Date of 8/30/47  
Where and how occur? RT/3 South of Salisbury  
(City or town) (County) (State)

Injured at home, farm, industry, public place (Where?) Cub's place

Means of injury Automobile Injured at work? No

23. SIGNATURE Harry Ashcraft M.D.

Address Prickers Chapel Date signed 9/1/47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

1000 1000 1000

1000 1000 1000

RECEIVED  
SEP 4 1947  
BUREAU V.S.

1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000  
1000 1000 1000

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07460

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County... WicomicoCity or town... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:  
P.S. - Hyatt

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... WicomicoCity or town... Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No... P.O. # 3  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Theodore Samuel Heame

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug. 12 1947 at 5:56

## 6. (b) Name of husband or wife

Nellie H. Heame6. (c) If alive, give age 59 years

7. Birth date of deceased (mo., day, yr.)

June 30 - 1899

## 8. AGE:

Years

Months

Days

If less than one day

68112

hrs. min.

## 9. Birthplace

P.O. # 3 Salisbury Md.  
(Town, county, and state)

## 10. Usual occupation

Farmer

## 11. Industry or business

## FATHER

## 12. Name

Samuel S. Heame

## 13. Birthplace

P.O. # 3 Salisbury Md.

## MOTHER

## 14. Maiden name

Frances C. Gilchrist

## 15. Birthplace

P.O. # 3 Salisbury Md.

## 16. Informant

Mr. Nellie H. Heame

## Address

P.O. # 3. Salisbury Md.

## 17. Burial

Aug 14 - 47

## (Burial, cremation, or removal (Which?))

Funeral home

## Cemetery or crematory

Salisbury Md.

## Location

William & G. Walter R. Williams

## 18. Funeral director

Salisbury Md.

## Address

8/14/47

## 19. (Date rec'd by registrar)

8/14/47

## 23. SIGNATURE

Frank R. Gramer M.D.

## M.D. or other

Salisbury, Md.

## Date signed

8/14/47

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

July 12 1947 to Aug 12 1947and that I last saw him alive on Aug 12 1947

Immediate cause of death

Coronary Occlusion

## DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Frank R. Gramer M.D.

M.D. or other

Date signed 8/14/47

MARGIN RESERVED FOR BINDING

VS A15

9.45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1947

BUREAU P S

Reg. Diat. No. 333

Address Wabash, Ind. Date signed 5/21/41

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 4 1947

BUREAU # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07462

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Dist. of Columbia County City or town Washington  
(If outside city or town limits, write RURAL and give nearest town)Street No.   
(If rural, give LOCATION)2.(a) If veteran, name war 

## 3. (a) FULL NAME

Insky, Mrs. Annie Esther

## 3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced widow6. (b) Name of husband or wife James P. Insky7. Birth date of deceased (mo., day, yr.) December 18, 18748. AGE: Years 72 Months 7 Days 19 It less than one day  hrs.  min. 9. Birthplace Bivalve, Wicomico, Maryland  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Class Foreman13. Birthplace Unknown14. Maiden name Julia Barclay15. Birthplace Nantuxie, Maryland16. Informant Mrs. Reese HornerAddress Dyaskin, Maryland17. Burial Date thereof August 10, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Bivalve Church CemeteryLocallon Bivalve Maryland18. Funeral director C. H. MessickAddress Bivalve, Maryland19. 8/9 47 1947 Harriet E. Johnson  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 7 19 47 at 5:42 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from death on arrival 19 and that I last saw him alive on 19 Immediate cause of death Coronary artery

## DURATION

occlusion 1 hr.Due to Due to Other conditions 

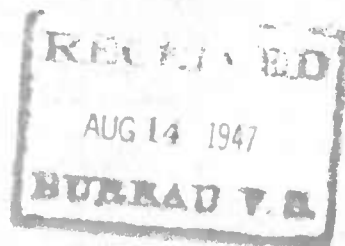
(Include pregnancy within 3 months of death)

Major findings of operations Date of op. Autopsy results 

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town) (County) (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 23. SIGNATURE Robert P. StarrAddress Salisbury, Md. Date signed 8-8-47



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 393

07463

### 1. PLACE OF DEATH:

County Wilcomia  
City or town Quantico Md  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred: no  
How long in hospital or institution? no

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State md County Wilcomia  
City or town Quantico md  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war no

### 3. (a) FULL NAME

John Wesley Jones  
4. Sex male 5. Color or race a.a. 6. (a) Single, married, widowed, or divorced married  
6. (b) Name of husband or wife Ella Jones  
yes no 6. (c) If alive, give age \_\_\_\_\_ years  
7. Birth date of deceased (mo., day, yr.) July 20 1867  
8. AGE: Years 90 Months \_\_\_\_\_ Days \_\_\_\_\_ It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

### 3. (b) Social Security Number

no

### MEDICAL CERTIFICATION

2D. DATE OF DEATH Aug 1st 19 47 at 2:30 A.M.  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 1st 19 47 to July 31st 19 47  
and that I last saw him alive on July 31st 19 47  
Immediate cause of death Cerebral Hemorrhage

#### DURATION

Due to \_\_\_\_\_  
Due to \_\_\_\_\_  
Other conditions Arteriosclerosis  
(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

9. Birthplace Quantico md  
(Town, county, and state)  
10. Usual occupation Farmer  
11. Industry or business same as above  
FATHER 12. Name John Wesley Jones  
13. Birthplace Princes Anne md  
MOTHER 14. Maiden name Paritta Garley  
15. Birthplace Quantico md  
16. Informant Ella Jones  
Address Quantico  
17. Burial Date thereof August 3, 1947  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Quantico md  
Location Quantico  
18. Funeral director James H. Stewart  
Address Salisbury md  
19. 8/3 19 47 H. H. Haggis Registrar  
(Date rec'd by registrar)

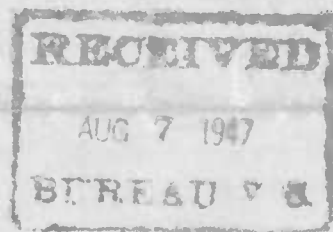
23. SIGNATURE William E. Smith M. D. or other  
Address Helen M Date signed Aug 2-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



Reg. Dist. No. 333

2.(a) If veteran, name war

**3. (b) Social Security Number**

Address \_\_\_\_\_ Date signed \_\_\_\_\_

**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 26 1947

BUREAU 8

Aug 14

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The form is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

415 Davis St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County TalbotCity or town Wittman  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Wilbert F. Jones

## 3. (b) Social Security Number

none

4. Sex \_\_\_\_\_ 5. Color or race \_\_\_\_\_ 6. (a) Single, married, widowed, or divorced \_\_\_\_\_

malewhitewidower8. (b) Name of husband or wife Elizabeth Jones

8. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) Jan. 15, 1876

8. AGE: Years \_\_\_\_\_ Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Wittman, Md.  
(Town, county, and state)10. Usual occupation Waterman

11. Industry or business \_\_\_\_\_

12. Name John W. Jones13. Birthplace Wittman, Md.14. Maiden name unknown15. Birthplace unknown16. Informant J. Walter JonesAddress Wittman, Md.17. Burial Aug 26, 1947  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Olivet CemeteryLocation St. Michaels, Md.18. Funeral director Newnam & HarrisonAddress St. Michaels, Md19. 8/25/47 H. L. Harrison Registrar  
(Date rec'd by Registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23, 1947 at 10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 9, 1947 to August 23, 1947 and that I last saw him alive on August 23, 1947Immediate cause of death Cardiac Failure

DURATION

Due to Arteriosclerosis

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Robert J. Gore, M.D.Address Salisbury, Md. Date signed 8/25/47

RECEIVED

SEP 3 1947

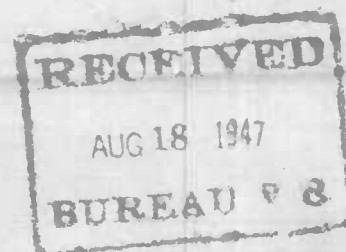
BUREAU 12

## Reg. Diat. No. 533

Address ..... Date signed .....

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The coverage is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1310

07467

## CERTIFICATE OF DEATH

Reg. Dist. No.

337

## 1. PLACE OF DEATH:

County WicomicoCity or town Nanticoke  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? lifetime

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State md. County WicomicoCity or town Nanticoke  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Leon Nutter

## 3. (b) Social Security Number

4. Sex

m

5. Color or race

col

6. (a) Single, married, widowed, or divorced

Widower

6. (b) Name of husband or wife

unknown

7. Birth date of deceased (mo., day, yr.)

June 5, 1888

6. (c) If alive, give age \_\_\_\_\_ years

8. AGE:

Years

Months

Days

If less than one day

59220

hrs.

min.

9. Birthplace

Nanticoke, Wicomico, Md.  
(Town, county, and state)

10. Usual occupation

Oysterman

11. Industry or business

FATHER

12. Name

unknown

13. Birthplace

"

MOTHER

14. Maiden name

Washie Nutter

15. Birthplace

Nanticoke, Md.

16. Informant

Paul Nutter

Address

Nanticoke, Md.

17.

(Burial, cremation, or removal. Which?)

Date thereof

8/31/47  
(month) (day) (year)

Cemetery or crematory

Nanticoke Cemetery

Location

near Jeters Store

18. Funeral director

C. H. Messersick

Address

Buwalde, Md.

19.

(Date reg'd by registrar)

19

47

Richard H. Sanders  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 26 19 47 at 2 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

28 March 19 47 to 26 August 19 47and that I last saw him alive on 26 August 19 47

Immediate cause of death

Arteriosclerotic Cardiovascular  
renal disease with terminalDue to: Wicomico

DURATION

10 days

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

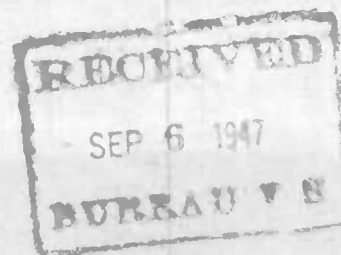
23. SIGNATURE

Richard H. Sanders MD

M. D. or other

Address

Nanticoke MdDate signed 30 Aug 47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Sharptown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)

State Md County WicomicoCity or town Sharptown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Owens, Orastus W.

## 3. (b) Social Security Number

## 4. Sex

M

## 5. Color or race

W.

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Josephine Owens

## 7. Birth date of deceased (mo., day, yr.)

June 14, 1869

## 6. (c) If alive, give age \_\_\_\_\_ years

## 8. AGE:

Years

Months

Days

If less than one day

78216

hrs.

min.

## 9. Birthplace

Baltimore Md.  
(Town, county, and state)

## 10. Usual occupation

Merchant

## 11. Industry or business

Gen. Merchandise

## FATHER

## 12. Name

Elisha Owens

## 13. Birthplace

Balto Md.

## MOTHER

## 14. Maiden name

unknown

## 15. Birthplace

## 16. Informant

Mrs. Mildred Fisher

## Address

Hebron Md.

## 17.

Burial  
(Burial, cremation, or removal. Which?)

## Date thereof

9/1/47  
(month) (day) (year)

## Cemetery or crematory

Red Men's Cem.

## Location

Sharptown Md.

## 18. Funeral director

David K. Messick

## Address

Hebron Md.

## 19.

9/1/47  
(Date rec'd by registrar)

## 19.

H. P. Haggard & Johnson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 30 1947 at 5 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_

and that I last saw him/her alive on \_\_\_\_\_ 19\_\_\_\_

## Immediate cause of death

Coronary Occlusion

## Due to

chronic myocarditis

## Due to

cardiac asthma

## Other conditions

Hypertension

(Include pregnancy within 3 months of death)

## Major findings of operations

none

## Date of op. \_\_\_\_\_

## Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide

Date of \_\_\_\_\_

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Harold Haggard M.D.  
Harold Haggard M.D.

M. D. or other

## Address

Sharptown Md.Date signed 8/30/47

RECEIVED

SEP 4 1947

BUREAU V S

Dr. Yeaman

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

932

07471

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

1. PLACE OF DEATH: *Wilcomie*  
 County.....  
 City or town.....  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
*551. S. Division st.*  
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State.....*MD.* County.....*Wilcomie*  
 City or town.....*Salisbury*  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....*551. S. Division st.*  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

3. (a) FULL NAME *Dorilla Maudel Parson*

3. (b) Social Security Number

4. Sex *Female* 5. Color or race *White* 6.(a) Single, married, widowed, or divorced *Married*  
 6.(b) Name of husband or wife *Clayton W. Parson*  
 6.(c) If alive, give age *79* years  
 7. Birth date of deceased (mo., day, yr.) *Nov. 4 - 1875*  
 8. AGE: Years *71* Months *9* Days *7* If less than one day  
 hrs. min.

9. Birthplace.....*Pittsville Md.*  
 (Town, county, and state)

10. Usual occupation.....*House wife*

11. Industry or business.....

12. Name.....*Minnie Parker*

13. Birthplace.....*Pittsville Md.*

14. Maiden name.....*Charlotte Buntingham*

15. Birthplace.....*Pittsville Md.*

16. Informant.....*Mr. Clayton W. Parson*

Address.....*551. S. Div. st. Salisbury Md.*

17. (Burial, cremation, or removal, which?) *Burial* Date thereof.....*Aug 13 - 1947*  
 (month) (day) (year)

Cemetery or crematory.....*Parson's Cem.*

Location.....*Salisbury Md.*

18. Funeral director.....*Will May & Co. Walter R. Williams*

Address.....*Salisbury Md.*

19. Date read by registrar.....*8/13/47*

Registrar.....*Barrie G. Johnson*

Address.....*Salisbury, Md.*

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....*Aug. 11* 19*47*

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
*July 1* 19*47*, to *Aug 11* 19*47*,  
 and that I last saw him alive on.....19.....

Immediate cause of death.....*Chagrin Heart Failure*  
*with myocarditis.*

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where and injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....*Arthur H. Yeaman M.D.*

M. D. or other

Address.....*38 Camden Ave.* Date signed.....*Aug 11, 1947*

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 18 1947

BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07469

## CERTIFICATE OF DEATH

Reg. Dist. No. 330

## 1. PLACE OF DEATH:

County.....Hicomico  
 City or town.....Mardela Md R.D.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?.....60 years  
 Hospital, institution, or street address where death occurred:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED

(For newborn infants give residence of mother)  
 State.....Md County.....Hic  
 City or town.....Mardela R.D. Md  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Maay E. Phillips

## 3. (b) Social Security Number

4. Sex.....F 5. Color or race.....W 6.(a) Single, married, widowed, or divorced.....Widow

6.(b) Name of husband or wife.....Zachariah S. Phillips

7. Birth date of deceased (mo., day, yr.).....Feb 13 1857 8.(c) If alive, give age.....years

8. AGE: Years.....90 Months.....6 Days.....2 If less than one day.....hrs.....min.

9. Birthplace.....Mardela Hic Md  
 (Town, county, and state)

10. Usual occupation.....Housework

## 11. Industry or business

12. Name.....Thomas B. Kemserly

13. Birthplace.....Md

14. Maiden name.....Elizabeth Graham

15. Birthplace.....Md

16. Informant.....Radie Shiles

Address.....Mardela R.D.

17. Burial.....Burial Date thereof.....8 19 47  
 (Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory.....Riverton

Location.....Riverton Md

18. Funeral director.....Gravenor Bros

Address.....Sharpton

19. 8/19/47 19.....MAH  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....8/16 19.....47 at.....3 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
July 1st 1947 to.....August 15 1947  
 and that I last saw him alive on.....Aug 15 1947

Immediate cause of death.....Chronic Myocarditis

Due to.....

Due to.....

Other conditions.....Arteriosclerosis

(Include pregnancy within 3 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury..... Injured at work?

23. SIGNATURE.....William E. Smith

Address.....Hicomico Md. Date signed.....Aug 16-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF NEW YORK

MEDICAL CERTIFICATION

RECEIVED

AUG 25 1947

BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 8338

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 55 years  
 Hospital, institution, or street address where death occurred:  
600 N. Division St.  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 600 N. Division St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

M. Lizzie Powell

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single-married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

8. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) August 20, 1854

8. AGE: Years 93 Months 0 Days 2 If less than one day hrs. min.

9. Birthplace Worcester Co. Maryland  
(Town, county, and state)10. Usual occupation At home

11. Industry or business

12. Name Robert Wanda Powell13. Birthplace Worcester Co. Maryland14. Maiden name Ann Holland15. Birthplace Worcester Co. Maryland16. Informant Mrs. Walter J. PowellAddress 600 N. Division St. Salisbury17. Burial (Burial, cremation, or removal) Which? Burial Date thereof 8/23/47  
(month) (day) (year)Cemetery or crematory Chesapeake CemeteryLocation Salisbury, Maryland18. Funeral director Wm. H. Johnson & Co.Address Salisbury, Maryland19. 8/23 1947 Registrar Wm. H. Johnson

(Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 22, 1947 at 5:30 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 22 1947and that I last saw him alive on Aug 17 1947Immediate cause of death Chronic myocarditis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. H. Johnson M. D. or otherAddress Salisbury, Md. Date signed Aug 22

MARGIN RESERVED FOR BINDING

VS A15

9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

43099

UNITED STATES DEPARTMENT OF JUSTICE

FEDERAL BUREAU OF INVESTIGATION

RECEIVED  
SEP 3 1941  
BUREAU OF INVESTIGATION

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County WicomicoCity or town Salisbury, Maryland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County SomersetCity or town Princess Anne  
(If outside city or town limits, write RURAL and give nearest town)Street No. P.R.#2  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Levitt, Mr. John W.

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

3 April 3, 1866

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age ..... years

8. AGE:

Years

Months

Days

It less than one day

81423

hrs.

min.

9. Birthplace

Mt Vernon, Somerset, Md.  
(Town, county, and state)

10. Usual occupation

Waterman

11. Industry or business

Sonny's Oysters

FATHER

12. Name

Robert P. Levitt

13. Birthplace

Mt Vernon Md.

MOTHER

14. Maiden name

W. H. K. K. K. K.

15. Birthplace

16. Informant

Mrs. Vaughn Moore

Address

Richmond Va.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Ashbury Cemetery

Location

Mt Vernon

18. Funeral director

Wale Washell

Address

Princess Anne Rd

19.

(Date rec'd by registrar)

8/28/47H. L. H. H. H.John W. Levitt

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 26<sup>th</sup> 19 47 at 5<sup>25</sup> P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 25<sup>th</sup> 19 47 to August 26<sup>th</sup> 19 47 and that I last saw him alive on August 26<sup>th</sup> 19 47

Immediate cause of death

Acute Coronary Artery Occlusion

DURATION

24 hrs.

Due to

Arteriosclerosis of Coronary Arteries

Symptoms

2 weeks

Other condition

HypertensionUnknown

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

David J. Lehigh  
301 N. Division  
Salisbury

M. D. or other

Date signed Aug. 26, 1947

RECEIVED

SEP 3 1947

BUREAU # 8

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County WicomicoCity or town Willards Md  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County WicomicoCity or town Willards  
(If outside city or town limits, write RURAL and give nearest town)Street No. R.D. 8<sup>th</sup>  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

Evelyn Agnes Rayne

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Thomer B Rayne6. (c) If alive, give age 59 years

## 7. Birth date of

deceased (mo., day, yr.)

Nov. 29, 1889

## 8. AGE:

Years

Months

Days

If less than one day

5791

hrs.

min.

## 9. Birthplace

Willards Wicomico, Md.  
(Town, county, and state)

## 10. Usual occupation

House wife

## 11. Industry or business

House wife

FATHER

## 12. Name

Ashur Campbell

## 13. Birthplace

Wheatonsville Maryland

## 14. Maiden name

Kate Ryan

## 15. Birthplace

Wheatonsville, Md.

## 16. Informant

Thomer B. Rayne

## Address

Willards Maryland

## 17.

Buried  
(Burial, cremation, or removal. Which?)

Date thereof

Sept 2-1947  
(month) (day) (year)

## Cemetery or crematory

Dennis

## Location

South of Willards Md

## 18. Funeral director

Wm Howard Wells

## Address

Pittsville Md

## 19.

9/2, 1947  
(Date read by registrar)

## 19.

H. B. Bessie L. Johnson  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 30, 1947 at 9P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from August 30, 1947 to Aug 30, 1947 and that I last saw him/her alive on 8-30-47 19.

## Immediate cause of death

Cerebral hemorrhage  
myocarditis (chronic)

## DURATION

2 hours

## Due to

## Due to

## Other conditions

Chronic interstitial nephritis  
Hypertension  
(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Frank R. Jones M.D.  
M. D. or otherAddress Willards Md. Date signed 9-1-47.

RECEIVED

SEP 4 1947

BUREAU 68

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. Line correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07474

## CERTIFICATE OF DEATH

Reg. Dist. No. 993

## 1. PLACE OF DEATH:

County FrederickCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 days

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? same

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County FrederickCity or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)Street No. 720 S. Washington  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Rayne, Mr. John C.4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Mrs. Marie Rayne7. Birth date of deceased (mo., day, yr.) Aug 15, 19306. (c) If alive, give age 12 years8. AGE: Years 67 Months 0 Days 4 If less than one day

hrs. min.

9. Birthplace Frederick, Md.  
(Town, county, and state)10. Usual occupation Farmer

11. Industry or business

12. Name Marie Rayne13. Birthplace Md.14. Maiden name Marie Manning15. Birthplace Md.16. Informant Marie RayneAddress Waldorf, Md.17. Buried Date thereof (month) (day) (year)

(Burial, cremation, or removal, Which?)

Cemetery or crematory Woods Chapel CemeteryLocation Waldorf, Md.18. Funeral director My. Parker WatsonAddress Salisbury, Md.19. 8/19 1947 H. H. Cassel, Jr. Registrar

(Date rec'd by registrar)

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 19 1947 at 9 am W

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

6 Aug 1947 to 14 Aug 1947and that I last saw him alive on 14 Aug 1947Immediate cause of death Hyperextension encephalopathyDue to hyperextension encephalopathyDue to stroke disease

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE H. H. Cassel, Jr. M.D.Address 504 N. Division St. Date signed 19 Aug 47

M. D. or other

RECEIVED

AUG 26 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Peninsula General HospitalHow long in hospital or institution? 10 days - 5 hrs. 45 mins.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WicomicoCity or town Pt.ville  
(If outside city or town limits, write RURAL and give nearest town)Street No. P. 710  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (a) FULL NAME

Sprott, Mrs. Signe

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Robert Sprott7. Birth date of deceased (mo., day, yr.) Nov 20, 1884 6. (c) If alive, give age \_\_\_\_\_ years8. AGE: Years 62 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Sweden  
(Town, county, and state)10. Usual occupation House work11. Industry or business Home12. Name FATHER ?13. Birthplace FATHER ?14. Maiden name MOTHER ?15. Birthplace MOTHER ?16. Informant Thomas HallAddress Pittsville, Md17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Aug 26-1947  
(month) (day) (year)Cemetery or crematory First MethodistLocation Delmar, Del.18. Funeral director W. S. Marvel CoAddress Delmar, Del.19. 8/26/47 (Date rec'd by registrar) H. H. Hargrett, Jr. Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 23rd 19 47 at 10 55 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 13 19 47 to Aug 23 19 47 and that I last saw her alive on Aug 23 19 47

Immediate cause of death

Pleural Effusion, right 48 hrsArterio-sclerotic heart disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Lucas R. Grance md. M. D. or other \_\_\_\_\_Address Salisbury Date signed 8/24/47

RECEIVED  
SEP 8 1947  
BUREAU OF

MARGIN RESERVED FOR BINDING

This is a permanent record. The spaces are arranged for typewriter use. Please fill out with typewriter (except signatures) or write plainly with unfading black ink. Every item of information should be carefully supplied. Age should be stated exactly; if unknown, give approximate age. Physicians should state cause of death in plain terms if possible, so that it may be properly classified. Exact statement of occupation is important and must not be omitted.

BUREAU OF  
VITAL STATISTICSCERTIFICATE OF DEATH  
STATE OF DELAWARE  
BOARD OF HEALTH

FILE NO.

REGISTERED NO.

## 1. PLACE OF DEATH:

(A) COUNTY Delaware  
(B) HUNDRED Laurel  
(C) CITY OR TOWN Laurel  
(If outside city or town limits, write RURAL)  
(D) NAME OF HOSPITAL OR INSTITUTION: Laurel Hospital  
(If not in hospital or institution write street number or location)  
(E) LENGTH OF STAY IN HOSPITAL OR INSTITUTION: 18 years (Specify whether years, months or days)  
IN THIS COMMUNITY 18 years

## 2. USUAL RESIDENCE OF DECEASED:

(A) STATE Delaware (B) COUNTY Laurel  
(C) CITY OR TOWN Laurel (If outside city or town limits, write RURAL)  
(D) STREET NO. 1700 07476  
(If rural give location with respect to the nearest town)  
(E) IF FOREIGN BORN, HOW LONG IN U. S. A. 18 years

## 3 (A) FULL NAME

## 3 (B) IF VETERAN,

## 3 (C) SOCIAL SECURITY

## NAME WAR

## NO.

4. SEX Male 5. COLOR DR Leol 6. (A) SINGLE, WIDDED, MARRIED, DIVORCED Married  
(B) NAME OF HUSBAND OR WIFE Induced L. Stevens 6. (C) AGE OF HUSBAND OR WIFE IF ALIVE 35 YRS.  
7. BIRTH DATE OF DECEASED April 6 1902 (Month) (Day) (Year)

8. AGE: YEARS 45 MONTHS 14 DAYS 10 IF LESS THAN ONE DAY  
HR. MIN.

9. BIRTHPLACE Payton (City, town, or county) Virginia (State or foreign country)

10. USUAL OCCUPATION Laurel

## 11. INDUSTRY OR BUSINESS

FATHER { 12. NAME do not know  
13. BIRTHPLACE (City, town, or county) (State or foreign country)

MOTHER { 14. MAIDEN NAME do not know  
15. BIRTHPLACE (City, town, or county) (State or foreign country)

16. (A) INFORMANT'S OWN SIGNATURE Induced L. Stevens(B) ADDRESS Laurel Del

17. (A) Burial (B) DATE THEREOF 8-20-47 (Month) (Day) (Year)  
(Burial, cremation, or removal)

(C) PLACE; BURIAL OR CREMATION Payton Va

18. (A) SIGNATURE OF Richard L. Fisher  
FUNERAL DIRECTOR

(B) ADDRESS Laurel Del

19. (A) 8/19/47 (B) Barrie L. Jones (Date received local registrar) (Registrar's signature)

## MEDICAL CERTIFICATION

20. DATE OF DEATH: MONTH Aug DAY 16  
YEAR 1947 HOUR 7:00 MINUTE 45 AM

21. I HEREBY CERTIFY, THAT I TOOK CHARGE OF THE REMAINS DESCRIBED ABOVE, HELD AN Inquest THERE ON AND FROM THE EVIDENCE OBTAINED BY SAID Inquest FIND THAT THE DECEASED CAME TO Death DEATH ON DAY STATED ABOVE.  
W. T. Conway  
Coroner

IMMEDIATE CAUSE OF DEATH Concussion of brain and gross shock  
DUE TO Automobile accident  
DUE TO

OTHER CONDITIONS  
(Include pregnancy within 3 months of death)

MAJOR FINDINGS OF AUTOPSY:

DURATION

PHYSICIAN

Underline the cause to which death should be charged anatomically.

## 22. IF DEATH WAS DUE TO EXTERNAL CAUSES, FILL IN THE FOLLOWING:

(A) ACCIDENT, SUICIDE, OR HOMICIDE (SPECIFY) Accident  
(B) DATE OF OCCURRENCE 8-15-1947  
(C) WHERE DID INJURY OCCUR? Laurel Del (City or town) (County) (State)  
(D) DID INJURY OCCUR IN OR ABOUT HOME, ON FARM, IN INDUSTRIAL PLACE, IN PUBLIC PLACE? While at work  
(E) MEANS OF INJURY Automobile accident (Specify type of place)

23. SIGNATURE Barrie L. Jones (M.D. OR OTHER)  
ADDRESS Laurel Del DATE SIGNED 8/16/47

RECEIVED

AUG 26 1947

BUREAU V S

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
City or town Salisbury Md.  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 weeks

Hospital, institution, or street address where death occurred:

416 Quail Hill ave.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Delaware County Dewey  
City or town Whitewater  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. R.F.D. #1 Pittsville Md.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Arthur George Thomas

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced MarriedMale White Married6. (b) Name of husband or wife Adella Florence Thompson6. (c) If alive, give age 60 years7. Birth date of deceased (mo., day, yr.) Aug 13, 18798. AGE: Years 68 Months 0 Days 15 If less than one day hrs. min.9. Birthplace Palmer New Jersey  
(Town, county, and state)10. Usual occupation MF Minister11. Industry or business Retired12. Name George Thomas13. Birthplace Palmer New Jersey14. Maiden name Mary Thompson15. Birthplace Palmer New Jersey16. Address Route #2 Pittsville Md.17. Burial (Burial, cremation, or removal Which?) Burial Date thereof Aug 31, 1947  
(month) (day) (year)Cemetery or crematory Line Church CemeteryLocation Near Whitewater18. Funeral director Wayne L. G. ShultzAddress 520 E. Church St. Salisbury Md.19. 8/30 19 47 Harriet E. Johnson Registrar  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 28 19 47 at 120P21. I certify that death occurred on the date above stated; that I attended deceased from January 19 46 to Aug 28 19 47  
and that I last saw him alive on Aug 28 19 47Immediate cause of death aplastic anemia DURATION

Due to

Due to

Other conditions fluoridosis: large red spots  
(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Injured at work?

23. SIGNATURE J. V. Schler M.D.

M. D. or other

Address Salisbury Md. Date signed 8-30-47

MARGIN RESERVED FOR BINDING

VS A15

9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
SEP 3 1947  
BUREAU OF

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07478

## CERTIFICATE OF DEATH

Reg. Dist. No. 383

## 1. PLACE OF DEATH:

County Worcester  
City or town Salisbury  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

71723

hrs.

min.

9. Birthplace

10. Usual occupation

11. Industry or business

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17. Burial, cremation, or removal, Which?

Date thereof

Cemetery or crematory

Location

18. General director

Address

19. (Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Street No.

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on

Immediate cause of death

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please indicate the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Name of injury

Injured at work?

23. SIGNATURE

Address

Date signed

MARGIN RESERVED FOR BINDING

VS A15 9-45-15M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 15 1947  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

07479

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salesburg, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5-30-47  
 Hospital, institution, or street address where death occurred:  
Pen. & Soc. Home at Salisbury  
 How long in hospital or institution? 5-30-47

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State md County Worcester  
 City or town Bishop  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Rt. 2  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Annie Walker

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Edward Walker  
 7. Birth date of deceased (mo., day, yr.) Jan 1, 1883 6.(c) If alive, give age 72 years  
 8. AGE: Years 64 Months 7 Days 6 If less than one day  
md. hrs. min.

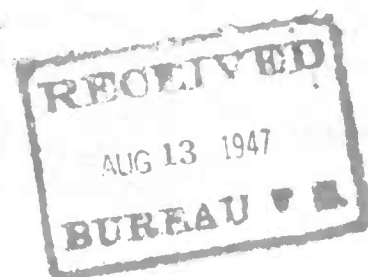
9. Birthplace md. (Town, county, and state)  
 10. Usual occupation housewife  
 11. Industry or business "  
 12. Name Isaac Nichols  
 13. Birthplace md.  
 14. Maiden name Jennie Fank  
 15. Birthplace md.  
 16. Informant Edward Walker  
 Address Bishop md.  
 17. Burial Date thereof 8/9/47  
 (Burial, cremation, or removal, which?) (month) (day) (year)  
 Cemetery or crematory Bishopville md.  
 Location Bishopville  
 18. Funeral director M. Vaska Watson  
 Address Silbyville, Md.  
 19. 8/17 47 Registrar John J. Johnson  
 (Date rec'd by registrar) (month) (day) (year)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 6 1947 at 12:45 P.M.  
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 30 1947 to Aug 6 1947  
 and that I last saw him alive on Aug 6 1947  
 Immediate cause of death Diabetes Mellitus DURATION 1 year  
 Due to  
 Due to  
 Other conditions Arteriosclerosis  
Arteriosclerotic changes, right foot 2nd  
 (Include pregnancy within 3 months of death)  
 Major findings of operations Occlusion of vessels  
lower right leg Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_  
 23. SIGNATURE David J. Schure M.D. M.D. or other  
301 N. Division Date signed Aug 7, 1947  
 Address Salisbury md.



## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

93d

07480

## CERTIFICATE OF DEATH

Reg. Dist. No. 939

## 1. PLACE OF DEATH:

County... Thiomis  
 City or town... Allen  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 54 years  
 Hospital, institution, or street address where death occurred:  
 ✓  
 How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... MD. County... Thiomis  
 City or town... Allen  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ✓  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

Weischel P. Hallare

## 3. (b) Social Security Number

✓

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
 6.(b) Name of husband or wife... ✓  
 7. Birth date of deceased (mo., day, yr.) Nov. 18, 1892 6.(c) If alive, give age... ✓ years

8. AGE: Years 54 Months 7 Days 13 If less than one day... hrs. min.

9. Birthplace Allen, Thiomis, Md.  
 (Town, county, and state)  
 10. Usual occupation U. S. Postman

## 11. Industry or business

12. Name W. Adward Hallare  
 13. Birthplace Sonoma Co., Md.

14. Maiden name Ella Phoebe  
 15. Birthplace Thiomis Co., Md.

16. Informant W. Fred Hallare  
 Address 1138 Walnut St., Chevy, Pa.

17. Burial Date thereof 8/3/47  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Methodist Church  
 Location Allen, Md.

16. Funeral director The Will & Son Co.  
 Address Salisbury, Md.

19. 8/3 19 47 W. Fred Hallare Registrar

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 1 19 47, at 6 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 12<sup>th</sup> 19 40 to Aug 1<sup>st</sup> 19 47  
 and that I last saw him alive on July 31<sup>st</sup> 19 47

Immediate cause of death Myocardial failure DURATION 2 mo.

Due to Ch. Myocarditis 1 yr.

Due to Hypertension 7 yrs.

Other conditions Infantile paralysis since childhood

(Include pregnancy within 3 months of death)

Major findings of operations... Date of op...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE W. Fred Hallare M. D. or other

Address Pharmacia Date signed 8/2/47

MARGIN RESERVED FOR BINDING

VS A15 9.45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
AUG 7 1947  
BUREAU V E

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07481

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Wicomico  
 City or town Salisbury  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R.O. #1  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mary M. Washburn

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow6. (b) Name of husband or wife Charles Washburn6. (c) If alive, give age Dead years7. Birth date of deceased (mo., day, yr.) Aug. 3<sup>rd</sup> 18728. AGE: Years 75 Months 6 Days 17 hrs.  min. 9. Birthplace R.O. #1, Salisbury Md.  
(Town, county, and state)10. Usual occupation House wife11. Industry or business at home12. Name John Fielder13. Birthplace Shad. Point Md.14. Maiden name Elijah McKeath15. Birthplace Shad Point Md.16. Informant Mrs. Elda TownsendAddress R.O. #1, Salisbury Md.17. Buried Date thereof Aug 22-47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Shad Point Mem.Location Shad Point Maryland18. Funeral director Harry May & Co. BaltimoreAddress Salisbury Maryland19. 8/22/47 Registrar Charles H. Simon

(Date read by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 20<sup>th</sup> 1947 at 9 a.m.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan. 1947 to Aug. 20 1947 and that I last saw him alive on Aug. 19 1947Immediate cause of death Coronary Heart Failure DURATION 1 yr.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

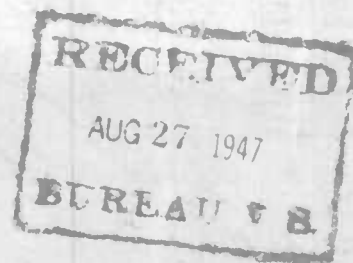
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Lee L. Laury M.D. M. D. or otherAddress Date signed 8-20-47



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07482

Reg. Dist. No. 933

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Pittsville Rural #2  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46 years  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Thomas J. Watson

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married

6. (b) Name of husband or wife

Minnie B. Watson

7. Birth date of deceased (mo., day, yr.)

April 26 - 1901

6. (c) If alive, give age

44 years

8. AGE:

46 Years 4 Months 3 Days hrs. min.

9. Birthplace

Pittsville, Wicomico, Md  
 (Town, county, and state)

10. Usual occupation

Produce Packer

11. Industry or business

Thomas J. Watson

12. Name

Maryland

13. Birthplace

Harriet M. Baker

14. Maiden name

Maryland

15. Birthplace

Mrs Minnie B. Watson

16. Informant

Pittsville, Md Rural #2

17. Burial, cremation, or removal. Which?

Burial

18. Location

Grace Methodist

19. Cemetery or crematory

Shaw Hill, Md.

20. Funeral director

Elmer C. Evans

21. Address

Shaw Hill, Md

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Wicomico

City or town Pittsville Rural #2  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. no  
 (If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

213-16-7445

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 29 19 47 at 9:15 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug. 29 19 47 to Aug. 29 19 47

and that I last saw him alive on Aug. 29, 1947

Immediate cause of death

Congestive Heart Failure

DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Charles W. Trader, M.D.  
 Address Shaw Hill, Md Date signed 9/30/47

19. 8/30, 19 47

(Date rec'd by registrar)

H. C. Evans  
 Registrar

RECEIVED

SEP 3 1947

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

131a

07483

## CERTIFICATE OF DEATH

Reg. Dist. No. 333

## 1. PLACE OF DEATH:

County Wicomico  
 City or town Salisbury, Md.  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Gen. Gen. Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Sancheester

City or town Cambridge  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 308 Oakley Street  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Lillian Wright

## 3. (b) Social Security Number

## 4. Sex

Female

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Widowed

## 6. (b) Name of husband or wife

Hubert H. Wright

6. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Aug. 9, 1873

## 8. AGE:

Years 74 Months 0 Days 11 less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

## 9. Birthplace

Chesterfield Co., Va.  
 (Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Gen. A. A. Whitmore

## 12. Name

Gen. A. A. Whitmore

## 13. Birthplace

Va.

## 14. Maiden name

Emma J. Robbette

## 15. Birthplace

Va.

## 16. Informant

W. H. Robbins

## Address

Cambridge, Md.

## 17. Burial

(Burial, cremation, or removal. Which?)

Burial

## Cemetery or crematory

Christ Church

## Location

Cambridge, Md.

## 18. Funeral director

Salisbury, Md.

## Address

Salisbury, Md.

## 19. (Date reported by registrar)

9/12, 1947

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 20 19 47 at 6 25 P M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 10 19 47 to Aug 20 19 47

and that I last saw her alive on Aug 20 19 47

Immediate cause of death

Cardio-vascular renal disease

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE \_\_\_\_\_ M. D. or other \_\_\_\_\_

Address Salisbury, Md. Date signed 8-23-47

RECEIVED

SEP 4 1947

BUREAU OF